Four Seasons (Bamford) Limited

Aarondale Care Home

Inspection report

Sunny Brow
Off Chapel Lane, Coppull
Chorley
Lancashire
PR7 4PF

Date of inspection visit:
06 February 2018
07 February 2018

Date of publication:
05 April 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 6 and 7 February 2017.

At our comprehensive inspection on 18 and 25 October 2016, we found several breaches of legal requirements. Some medicines' administration practices were unsafe and infection control measures were not robust.

In addition, people's dietary requirements were not always catered for, the service was not conducting effective mental capacity assessments and was not seeking consent from some people in relation to 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms.

There were also issues with auditing and checking on the provision of care and failure to spot the issues that we found during the inspection.

In addition to the breaches of the regulations, we made recommendations around areas involving potential fire hazards with soft toys, staffing levels, complaints' processes, areas of the home that required updating and that the service should look at ways of engaging people who use the service and provide activities.

We rated the home as 'Requires Improvement' and asked the provider to make improvements in all of these areas. They kept CQC informed of the changes that had been made.

At this inspection in February 2018 we found that significant improvements had been made in all these areas but have made a continuing recommendation around the need to provide variation in the provision of activities. We have now rated the home as 'Good'.

Aarondale Care Home is a 'care home' located in the Coppull in the county of Lancashire. The service does not provide nursing care. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 48 people. At the time of the visit there were 39 people who received support with personal care.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were not being deprived of their liberty inappropriately, DoLS applications were being made and the registered manager and staff were aware of the need to seek consent in line with the MCA.

Proper assessments were being made around ways of protecting people and people were being supported by well-trained staff.

People using the service said they felt safe and that staff treated them well. There were enough staff on duty and deployed throughout the home to meet people's care and support needs. Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported.

There was a whistle-blowing procedure available and staff said they would use it if they needed to report poor practice. Appropriate recruitment checks took place before staff started work.

We found that people and their relatives, where appropriate, had been involved in planning for their care needs. Care plans and risk assessments provided clear information and guidance for staff on how to support people using the service with their needs. Although improvement could still be made, there was a range of appropriate activities available for people to enjoy.

People and their relatives knew about the home's complaint's procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

The registered manager and provider conducted regular checks to make sure people were receiving appropriate care and support. The registered manager took into account the views of people using the service, their relatives and staff through meetings and surveys. The results were analysed and action was taken to make improvements at the home.

Staff said they enjoyed working at the home and received appropriate training and good support from the registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe and well cared for.

Medicines were securely stored, were safely administered and accurately recorded.

There were arrangements to deal with emergencies and staff were aware of signs of abuse and what action they should take.

There was a whistle-blowing procedure available and staff said they would use it if they needed to.

There were enough staff deployed within the service and safe staff recruitment procedures were in place.

There were appropriate assessments in place to support people where risks to health had been identified. Checks were carried out on equipment and the premises to reduce risk.

Is the service effective?

Good

The service was effective.

Staff had completed an induction and supervision when they started work and received training relevant to the needs of the people using the service.

The registered manager and staff demonstrated a clear understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and acted according to this legislation.

People told us they enjoyed the food and that there was a good choice available. People's fluid and food intake was monitored and staff encouraged people to eat and drink with appropriate action taken if people lost weight.

People had access to a wide range of healthcare services to ensure their day-to-day health needs were met.

Is the service caring?

Good

The service was caring.

Staff were caring and spoke with people in a respectful and dignified manner.

People's privacy and dignity was respected.

Staff knew people well and were aware of their preferences and routines.

People and their relatives were involved in making decisions about their day-to-day care.

Information and records were kept confidential and secure.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care files included detailed information and guidance for staff about how their needs should be met.

There were activities for people to participate in but consideration should be given to varying these to suit people's needs and abilities.

People knew about the home's complaint's procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Is the service well-led?

Good

The service was well-led.

There were other appropriate arrangements in place for monitoring the quality and safety of the service that people received.

Staff said they enjoyed working at the home and they received good support from the registered manager.

There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it.

The registered manager and provider carried out checks at the

home to make sure people were receiving appropriate care and support.

Aarondale Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 6 and 7 February 2018 and was unannounced.

The inspection team consisted of one adult social care inspector, who is the lead inspector for the service and an expert by experience, who had experience of caring for older adults and those living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this information together with other information we held about the home including notifications they had sent us. A notification is information about important events that the service is required to send us by law. We also received feedback from health care professionals that we used to help inform our inspection planning.

We spoke with a range of people about the home including 10 people who lived at the home, four visitors, including two visiting health care professionals and seven members of staff. In addition, we also spoke with two chefs, the deputy manager, the registered manager and a representative of the provider.

We looked at the care records of six people who lived at the home, training records and five recruitment records of staff members and records relating to the management of the service.

Good

Is the service safe?

Our findings

At our comprehensive inspection on 18 and 25 October 2016 we found that parts of the home were dirty, sluice rooms were in need of refurbishment and infection control measures were not robust.

Medicines' administration practices were unsafe in that the responsible staff member had left a medicines' trolley unattended whilst they administered medicines to people. This meant that unauthorised people could potentially access medicines.

These issues amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements in the cleanliness of the home. Sluice rooms had been refurbished and all areas of the home were clean and tidy. The local authority had conducted an infection control inspection in October 2017 and we noted that minor issues had been highlighted such as lack of pedal bins in some bedrooms. At our inspection we saw that every room had a clean pedal bin and most of the recommendations raised in the local authority report had been implemented. We noted that the recommendations that hadn't been acted on, such as redecoration of some areas of the home, were part of a program of improvements to be completed by the spring of 2018.

On the first day of the inspection we looked at how medicines were being administered to people. We noted that the medicines' trolley was always locked away whilst not being used in a designated room that only staff responsible for administering medicines had access to. This room's temperature and the medicines' fridge temperature were recorded and we noted that they fell within safe ranges.

We saw that people's permission was sought before medicine was administered and that people were gently encouraged to take their medicine. We also looked at the medicine administration records (MAR) for five people using the service and found these records were up to date and accurate. These records included a photograph of the person, known allergies and details of staff members authorised to administer medicines. One person's relative said, "I'm here most days and see that my relative get their medicines at the same time every day and staff always provide appropriate encouragement."

We saw up to date protocols were in place to advise staff when and under what circumstances people should receive any medicines that had been prescribed 'as required' and that this protocol had been approved by a local G.P. Staff and the registered manager told us what they would do when people required an 'as required' medicine.

We noted that the registered manager and provider made regular checks on the records relating to the administration of medicines. An external pharmacy completed annual reviews of the policies and records held at the home and this also included checks on medicine's stock and storage areas.

At our inspection in October 2016, we recommended that the service seek advice around soft toys in

bedrooms that could potentially present as a fire hazard. At this inspection in February 2018, we noted that in March 2017 the registered provider had commissioned a comprehensive fire risk assessment at the home by an independent specialist. We noted that all of the recommendations that were raised in that assessment had been acted upon at the time of our February 2018 inspection.

At the October 2016 inspection we also made a recommendation around a review of staffing levels as it was noted that people were waiting an unreasonable amount of time for staff to provide care and support. At our February 2018 inspection, we saw that there was a good staff presence. During the two days of the inspection we did not see anyone waiting for care and support and staff were attentive to people's needs. We checked staffing rotas for the month preceding the inspection and saw that there was a consistent level of staff on duty. The registered manager said, "We use a recognised staffing tool and took on board the recommendations at the last inspection. I think we've got the balance right."

People told us that they felt safe and well treated. One person said, "I feel safe and secure here and staff are very good with me." A health care professional said, "I have no concerns at this home about people being safe."

People's care files included a wide range of risk assessments in areas including mental capacity, moving and handling, medicines, weight loss, nutritional needs, continence care and skin integrity. People also had individualised risk assessments on behaviours that may challenge the service and their medical conditions. These provided guidance to staff on how they should support people so that the risk to them could be minimised. For example, where people were assessed as being at high risk of falling, it was noted that there were plans in place to support them with this and sensor devices were in place that could assist staff in alerting them when someone was at risk

There were arrangements in place to deal with foreseeable emergencies. People had personal emergency evacuation plans (PEEPs) which highlighted the level of support they required to evacuate the building safely. Records confirmed that staff received regular training on fire safety and we saw records confirming that the fire alarm was tested on a weekly basis and the conduct of monthly fire drills.

Records of accidents and incidents were maintained that contained information about each incident and any action that had been taken. The records supported that observations were made when people had a mishap such as fall and there were records when people had been referred to health care professionals.

There were policies and procedures in place to protect people using the service from the risks of abuse and avoidable harm. The registered manager and staff we spoke with demonstrated a clear understanding of the types of abuse that could occur in a care home setting and the signs they would look for. They were also aware of the action to take if they thought someone was at risk of abuse including whom they would report any safeguarding concerns to.

Records confirmed that the registered manager and all staff had received training on safeguarding adults from abuse. The registered manager and her deputy also attended specialist safeguarding forums rum by the local authority. A member of staff said, "We are all tuned in to the need to be vigilant around safeguarding. It's a high priority for us all."

Information from accidents and incidents, action plan audits, complaints and safeguarding alerts were analysed to help identify any patterns or areas requiring improvement and shared with the staff team at monthly meetings to look at lessons learned. This meant steps could be taken to reduce the risk of foreseeable harm occurring to people.

Thorough recruitment checks were carried out before staff started working at the home. We looked at the personnel files of five members of staff who had been recruited since the last inspection. The files contained completed application forms that included references to their previous health and social care experience, their qualifications and their employment history. Each file included two employment references, health declarations and proof of identification.

The service requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a statutory requirement for people providing a personal care service and supporting vulnerable people. The service checked this documentation prior to confirming a person's employment to ensure suitability for their role.

Equipment such as hoists and specialist chairs were well maintained and fit for purpose. They were regularly checked in the home and inspected and serviced annually by a specialist company. The registered manager said that all of the equipment that was in use at the home had been recently serviced and the records we saw supported this.

Good

Is the service effective?

Our findings

At the inspection in October 2016 we found that the kitchen staff were not aware of some people's dietary requirements.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we spoke with two chefs. The first was on the first day of the inspection just after the breakfast serving. They had been brought into the home from another home owned by the provider to cover for annual leave. They were aware of the needs of the people in the home and said, "A member of care staff greeted me first thing this morning and we went through the residents' requirements for the day." We spoke with another chef on the second day who was regularly employed at the home. They told us they spoke with people about their meal preferences. They were aware of people's dietary requirements and received daily notifications from staff that included any changes to their conditions.

We observed a mealtime on the first day of the inspection and saw that people received plenty to eat and drink. The atmosphere was relaxed and staff were available to offer support to people where required and we observed them gently encouraging people to eat in a relaxed an unhurried manner. We saw that one person was supported to eat and staff knew people's likes and dislikes. Most people ate together and appeared to enjoy the mealtime but one person chose to eat alone. One staff member said, "We try to make mealtimes as social as possible but people can eat alone or in their rooms if they prefer." One person using the service said, "The food is great. It's homemade and you get plenty."

During the inspection we noted that at times other than the set meal sittings, people were supported to eat snacks and drink sufficient quantities to maintain a balanced diet and ensure their well-being. Care plans identified people's nutritional needs and preferences and how staff could support them to eat a nutritious and healthy diet.

At the inspection in October 2016 we found that the service was not always conducting effective mental capacity assessments, was not always seeking consent and in one case this had led to the unauthorised use of a safety restraint on a chair.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we found improvements in the way the service addressed mental capacity and sought consent. The person who had used the specialist chair mentioned at the October 2016 inspection report, had subsequently been involved in a best interests meeting with their relatives and a healthcare professional. We were satisfied that the service was acting in accordance with the MCA and associated Codes of Practice.

People told us that staff asked for their consent before they provided care and we observed this to be the case throughout the inspection. The service assessed people's mental capacity and sought people's consent to the care, support and treatment that was provided. It was only when a person lacked capacity that the views of relatives and health care professionals were taken in to account in the person's best interests.

At the inspection we saw a situation where a person was distressed and required assistance and support to go to the hairdressers. The person had a disability and we observed that staff asked for permission throughout their involvement, reassured appropriately and explained their actions during their support of the person. We observed that the person became settled and calm during staff involvement and that the staff members involved dealt with the situation with care and understanding.

At this inspection, the registered manager told us that the home had made applications to the local authority to deprive people of their liberty. At the time of our inspection the local authority had granted two of these applications and was processing the rest. We saw three of the applications that had been made since the inspection in October 2016 and were satisfied that the home had raised them appropriately and in a timely manner.

At our inspection in October 2016 we found that the registered manager and staff were not fully aware of their roles and responsibilities around seeking consent from people when it related to 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A DNACPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. However the process for completion must be correct otherwise the form can be deemed invalid. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time.

At this inspection we found improvements in these areas. We saw three DNACPR forms within the care files we considered. The person's doctor had signed all of these and where people lacked capacity to give consent, best interest decisions had been taken in consultation with relatives and relevant health care professionals.

At the inspection in October 2016, we noted that some areas of the home required updating and made a recommendation around this. At this inspection in February 2018, we noted improvements and that a programme to update the home had been initiated by the provider. This had involved re-decoration and the replacement of some items of furniture. We saw that attention was still required particularly around

decorating parts of the home. The registered manager and provider's representative said that the programme of improvements was about two thirds through to completion. They said it was hoped that all areas should be completely renovated by the summer of 2018.

People using the service said staff and the registered manager knew them well and how best to support them. Visitors told us that staff were skilled at meeting the needs of people at the service and were competent in supporting them with complex conditions. They spoke highly about the care and support at the home. One person said, "They know how to look after me." A relative said, "My relative wouldn't be anywhere else. This is their home and the staff know precisely what to do." A health care professional who we met on the second day of the inspection said, "The staff support people and follow my recommendations properly. The senior carers here are particularly skilled."

Staff told us they had completed an induction when they started work and they were up to date with the provider's mandatory training. We saw completed induction records in all of the staff personnel files we looked at. The registered manager told us that staff new to care would be required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. Other staff we spoke with had completed training relevant to health and social care and some had previous experience of working in care settings. Staff had completed NVQ qualifications in adult social care and said that the provider supported and encouraged them to obtain these qualifications.

Training records showed that staff had completed training in areas including mental health, infection control, safeguarding adults, first aid, health and safety, moving and handling and equality and diversity. All senior carers had completed training and had received competency checks in the safe administration of medicines. We noted that staff received refresher training in these areas on a regular basis and that training records were up to date. Staff told us the training they received helped them effectively carry out their roles and responsibilities. One member of staff told us, "There's lots of training and we have a full programme including refreshers."

We found that people were supported to maintain good health. Records showed that people had access to a range of healthcare professionals including a GP, optician, chiropodist, and dentist. Staff also supported people to attend hospital appointments and visited them when they were admitted to hospital. We noted that records and advice to staff about the process of referring matters to external professionals was documented in the care records and on people's care plans.

Feedback about the service from healthcare professionals was positive. One healthcare professional told us, "Staff call on us appropriately." Another said, "The home acts properly to avoid unnecessary admissions to hospital."

Good

Is the service caring?

Our findings

All the people we spoke with and their relatives commented that the care provided was good. One person said, "The staff care for me very well and are very kind." One relative said, "I am constantly impressed with the caring nature of the staff the home employ." Another relative said, "The manager and staff always make us feel welcome and an integral part of the home." A healthcare professional said, "Staff are dignified and professional in their approach and I have no concerns about their care. They always protect people's dignity."

Staff had a good understanding of protecting and respecting people's human rights. All staff had received training that included guidance in equality and diversity. We discussed this with staff and they said that the registered manager promoted and encouraged these values. The provider's policy on equality, diversity and human rights was comprehensive and available to staff in the main office.

Staff said they knew people's likes and dislikes. One member of staff told us that they listened to people and gave them choices. Another said that the registered manager encouraged a family approach to the care that was provided. The registered manager said, "I am careful about who we employ and try to not rely on agency staff. I want the staff to treat people as if they are their own family and the home is small enough for us to have a team of regular staff who know the residents well." A person said, "I like my independence but the staff seem to know when and where to help me. Last week they helped me renew my bus pass."

All of the care files we looked at included a section on personal histories. This recorded the person's preferred name, hobbies and interests and the jobs they used to do. They were written respectfully and staff said that they read them and worked with people including relatives and health care professionals to deliver good care. All staff told us they recorded the care delivered in the daily log and we saw good examples of the recording of daily care in the records that we saw. People said they had been consulted about their care and support needs and where appropriate, their family members had also been involved. A person said, "I was involved in setting up the care plan at the beginning and all of the reviews."

People were treated with dignity and respect. We saw staff knocking on doors before entering, calling people by their preferred name and requesting permission to care and support people. One person said, "Staff never come into my room without knocking and make sure my privacy is protected." A relative said, "The staff always make my relative looks nice and help them with their appearance such as getting their hair done."

During the inspection we noted that staff knew people well and understood their needs. We saw examples of good care and saw that people were treated with understanding, compassion and dignity. Staff also encouraged people to communicate their day-to-day needs. For example, we saw staff support a person to a lounge to participate in activities. The person was worried that they were taking too long whilst they used their walking aid and staff asked if they wanted assistance. The support staff gave was reassuring and caring. Staff bent down to the person's level and their speech was warm and encouraging.

Most people using the service could voice their concerns and positions. Those that couldn't often had support from relatives but when people needed other support, they had access to an advocate. An advocate is a specially trained person who can help if a person does not have capacity to make particular decisions and would benefit from having an independent 'voice'.

We saw that there were arrangements in place for people to be involved in making decisions about their end of life wishes. Where appropriate, people were assisted with these sensitive issues by their family members. Where people had been consulted and had expressed preferences, these were recorded in their care plans.

Staff said they made sure information about people was kept locked away so that confidentiality was maintained at all times. We saw that all personal documentation including care plans and medicines records were locked away and this meant that only authorised staff accessed people's records.

Good

Is the service responsive?

Our findings

At our inspection in October 2016 we made a recommendation around the need to gather feedback and suggestions from people around activities. The feedback received at that inspection was mixed with many people suggesting that there wasn't a great deal going on at the home.

At this inspection in February 2018 we noted that the service had made improvements in this area. An activities coordinator was in place that worked Monday to Friday each week. We noted that the coordinator had arranged a daily schedule of activities. These included word association games and 1960's music based quizzes. On both days of the inspection we observed that people participated in these activities enthusiastically and were supported and encouraged by staff.

However, feedback from staff on the issue of activities was mixed. One said, "We seem to get the same entertainer in every couple of months." Another said, "We used to go out in a minibus but I haven't seen it being used for a long time." The activities coordinator said that they were supported to provide activities and that their role was solely to arrange and conduct activities in the home. However, we did note that the home had not arranged outings to places of interest in the ten months preceding the inspection and the same two singers had been used in the home on seven occasions in the past 12 months.

We recommend that the provider continue with the improvements in this area and take steps to vary the range of activities that are provided for people of all levels of capacity and capability.

At our inspection in October 2016 we made a recommendation around the need to write to a complainant with an outcome of their complaint.

At this inspection in February 2018 we noted that the home's policy incorporated the requirement to keep people informed of the progression of their complaint. In the two complaints that had been raised since the last inspection in October 2016, the home's procedure had been followed and the complainant was kept informed of the progression and conclusion of the complaint in writing.

People said they knew about the complaints' procedure and told us they would tell staff or the registered manager if they were not happy, or if they needed to make a complaint. Relatives also said they knew how to make a complaint if they needed to. They said they were confident they would be listened to and their complaints would be fully investigated. One person's relative said, "We know what to do and would raise a complaint if we needed to."

At our inspection in October 2016 we made a recommendation around the need to ensure that the home promoted a person centred approach to care. For example, we noted at that inspection that there was an institutionalised approach to bathing where people were only allowed to bathe on set days.

At this inspection in February 2018, we noted an improvement in this area. People said that they could have a bath whenever they wanted one. One person said, "I can ask for whatever I want and can do what I want.

There are no restrictions."

Care plans also supported a 'person centred' approach and included information such as how people liked to be addressed, their likes and dislikes, details about their personal history, their hobbies, pastimes and interests. For example, one person's care plan advised staff to call the person by their preferred middle name.

Throughout the course of our inspection we saw positive interactions between people using the service and staff. We noted that staff and the registered manager knew about the people who lived in the home and their likes and dislikes.

People's care files were detailed and the information contained within them was consistent and accurate. They were also personal to the person in question with personalised records of daily care staff had provided to people. The files were also easy to read and accessible. All of the care plans and risk assessments we looked at had been reviewed on a monthly basis or more frequently if required to ensure they were reflective or people's individual and current needs. The records showed that people and their relatives were involved in the reviews of care planning.

We saw that people's health care and support needs were assessed before they moved into the home and this assessment continued whilst the person lived at the home. These assessments covered areas including mental and physical health support needs, moving and handling, mobility, nutrition, communication, sleeping, emotional and spiritual needs, activities, medicines and continence. The registered manager told us that care plans were developed using the assessment information. For example, one person's care plan included information about how their susceptibility to falls had increased because of a hospital operation. Staff were alerted to the extra prevention measures that had been put in place to mitigate the risk of injury including the placing of sensor systems to alert staff so that support could be provided as they got up. This meant that the service provided individualised care that was up to date.

People's weight was regularly reviewed and where appropriate referrals were made to health care professionals. We saw examples of how the MUST risk assessment tool was completed in order to identify people's risk of malnutrition. MUST is a Malnutrition Universal Screening Tool and is a five step screening tool used to identify adults who are malnourished or at risk of being undernourished. A health care professional said, "We don't have concerns here. Staff are good at recognising issues quickly and get specialist help in."

The provider had an accessible information policy covering the requirements of the Accessible Information Standard. The Accessible Information Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. NHS and adult social care services are legally required to follow this standard.

In line with this standard, the provider had ensured that most policies relevant to people who used the service such as the complaints' policy, had been provided in accessible way. This was often through a person's relative. The provider's representative said, "We will produce our policies in many different formats. Whatever the requirements, we will ensure that people can access important documents."

The service supported and encouraged the use of technology to assist and support people. During the inspection we saw the use of technological aids to assist staff to support people such as the use of monition sensors to assist in the prevention of falls. In some cases staff assisted people with video and telephone conferencing for people to communicate with their relatives who lived abroad.

Good

Is the service well-led?

Our findings

At our comprehensive inspection in October 2016 we found that the service was not completing effective audits that were picking up on the issues that were found during the inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements in this area. The registered manager and senior staff were completing audits that were addressing issues around the home. These included food safety, health and safety, water temperatures, maintenance, cleaning, medicines, fire safety and care file audits. We also saw reports from spot checks. The registered manager said, "I am helped by a dedicated team of staff and this allows me to spend some time checking on essential areas that affect the welfare of the people we care for." For example, we saw that checks had established that some parts of the infection control audit mentioned in the 'safe' section of this report had not been implemented. We saw that the registered manager had taken action to resolve the matter.

The provider's representative also completed checks and on the first day of the inspection was seen to be completing audits on some of the registered manager's checks and these included environmental checks and care plan risk assessments.

In addition to the checks and audits, we saw that accidents and incidents were recorded and monitored and any quality issues were discussed at staff team meetings and measures were put in place to reduce the likelihood of these happening again.

Staff felt they could express their views at team meetings and said that the registered manager and provider were open to feedback. They said they liked working at the home and praised the support they received from the registered manager, their deputy and senior staff. We saw minutes from a staff meeting in October 2017 when the results of a fire risk assessment were discussed and from a meeting in January 2018, where it was highlighted to staff the people who were at high risk of falls. We noted that at these meetings, staff could raise issues, the discussions were open and the registered manager sought staff input on the matters that were raised.

A member of staff said, "We are completely supported by the manager and senior staff. We can bring any matters to their attention and have regular meetings where we are all encouraged to participate."

There was an out of hours on call system in operation that ensured that management support and advice was always available to staff when they needed it. A member of staff said, "We are completely supported by the manager and senior staff. We can bring any matters to their attention and have regular meetings where we are all encouraged to participate."

The registered manager took into account the views of people using the service about the quality of care

provided at the home through monthly resident meetings and annual surveys. We saw the minutes from the residents' meeting in November 2017 when people raised their meal preferences. The registered manager said, "I get feedback from residents and their relatives on a daily basis and immediately adapt to reflect people's preferences but the formal surveys are useful."

We reviewed the service's policy and procedure files that were available to staff in the main office. The files contained a wide range of policies and procedures covering all areas of service provision with both people and staff taken into account. We noted that reference to some policies such as equality and diversity was mandatory during a new member of staff's induction. We saw the policies and procedures were accessible to staff, up-to-date and regularly reviewed.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding and deprivation of liberty teams. Our records showed that the registered manager had appropriately submitted notifications to CQC and other agencies.